WORKING WITH SEX OFFENDERS

THIS SPECIAL SECTION, PRODUCED WITH THE ORGANISATION STOPSO, LOOKS AT THE ISSUES RAISED BY WORKING WITH BOTH SEX OFFENDERS AND SURVIVORS

SEX OFFENDING – AND HOW TO STOP IT

Juliet Grayson Explains why prevention is better than cure – every time

JULIET GRAYSON
UKCP Registered Psychotherapist, Chair and Co- founder of StopSO, The Specialist Treatment Organisation for the Perpetrators and Survivors of Sexual Offences

Have you ever had a client who, after a few sessions, revealed that they had been viewing child abuse images? Even for the most experienced therapists, it's difficult to know how to react when a client confesses to a crime – particularly one that has historically had so little discussion when it comes to the right therapeutic approach, treatment and possible outcome. That's why StopSO, The Specialist Treatment Organisation for the Perpetrators and Survivors of Sexual Offences, has dedicated a conference, Tackling Sexual Abuse in the 21st Century, in London on 2 May to the vital topic of sexual offending (find out more at stopso.org.uk/conference).

With the vast boom in illegal online pornography, increasingly, therapists are facing this challenging scenario. Some may not feel able to work with the issues themselves but need advice on referrals. Others cite the importance of working with this client group, and are keen to equip themselves with the specialist skills required to do so. Sadly, working with sex offenders is no longer a niche area.

In 2016-2017, there were 64,667 police-recorded sexual offences against children across the UK.

'We are dealing, unequivocally, with the tip of the iceberg,' Chief Constable Simon Bailey, the National Police Chiefs' Council Lead for Child Protection, told BBC2's *Panorama* (*When Kids Abuse Kids*), 'and we know that only one in eight reports are actually coming through to the police.'

By this reckoning, the true scale of child sexual abuse is likely to be around 517,336 sexual offences against UK children every year – or a staggering 9,949 a week, almost one new child being sexually abused every minute of the day.

My own interest in this controversial issue began when a non-offending paedophile contacted me to ask for help. I asked colleagues Glyn Hudson-Allez, a forensic psychologist, and Ruth Hallam-Jones, a UKCP registered psychosexual therapist, 'What help is there for people concerned they might touch a child, who haven't been arrested?'

Both had been working with active and potential sex offenders for decades yet the startling answer was, 'None'.

WINDOWS OF OPPORTUNITY

'If they are an internet offender looking at child abuse images, they can attend a group programme through the Lucy Faithfull Foundation (LFF), but only if they have been arrested, charged or convicted,' says Glyn. 'For those who have fantasies about children but have not yet touched one, there is the LFF StopItNow! helpline. Beyond that there's no therapeutic help.'

For people who have voyeuristic urges, exhibitionists or those who offend against adults, there is no support available until they have been imprisoned, Ruth went on – 'and even if they get convicted, they are often released before attending an Sex Offenders' Treatment Programme. Many go back into the community without any help.'

Shortly after this dispiriting conversation, a group of therapists got together to brainstorm. Many of us knew people who had struggled with sexually inappropriate behaviour, and had tried to find help to remain law-abiding. We shared stories of non-offending paedophiles seeking therapeutic help and not finding it, or being shamed by horrified therapists. In some cases, these clients had vowed never to look for help again.

We recognised that one significant way to reduce child and adult sexual abuse was to ensure that perpetrators who want to stop can directly access help. That's when we decided to create a UK-wide network of therapists open to working with people who commit sexual offences of all types: from troubling thoughts to acting out, and in 2011, The Specialist Treatment Organisation for the Prevention of Sexual Offending was born.

Understanding the roots of sexual offending is key to developing the right approaches. It's generally agreed that its genesis often lies in childhood trauma and attachment injuries, such as a parent dying, alcoholic parents, neglect, violence, bullying, or sexual abuse, and most sex offenders know they are different when they are still young. Eleven per cent know by the time they are 10, and a further 40 per cent realise between the ages of 11 and 16. By 25, a huge 72 per cent of sex offenders know they have inappropriate sexual thoughts or behaviour, yet most do not offend until their early thirties. This offers a crucial window of opportunity for education and therapeutic interventions targeting young adults.

Photos: Simone Padovani/Awakening/Getty Images

'We need a culture change in therapy, to make it acceptable to acknowledge a sexually inappropriate attraction'

A NEW APPROACH

We need a culture change in therapy, to make it acceptable to acknowledge a sexually inappropriate attraction and safe enough for people of any age to ask for help. One factor that could build trust is our use of language. Most of us mistakenly refer to 'paedophiles' when discussing child molesters. The definition of a paedophile is someone who has a primary or exclusive sexual interest towards prepubescent children (generally 11 and under) – but there are many non-offending paedophiles who never act illegally. There are also those who commit contact offences with a child, but their primary sexual interest is in adults.

Researcher James Cantor says, 'Paedophilia is a sexual orientation. It is something that we are essentially born with, and it's as core to our being as any other sexual orientation.' His research with prisoners shows that paedophiles tend to be up to 15 IQ points lower than average, 2.5cm shorter than the norm and three times more likely to be left handed. These characteristics are generally determined during the second trimester of pregnancy – suggesting that for some, paedophilia could be determined at the same time, and possible causes may include maternal stress or malnourishment. And though some people are born with paedophilia, for others it is brought on by childhood trauma or a blow to the head.

Most therapists know the devastating consequences of sexual abuse on all levels: physical, mental, emotional, and spiritual. But given that it costs approximately £65,000 to put someone in prison for a year (including court costs and police time), offering therapy in the community provides a very cost-effective solution. Let's imagine the government funded StopSO's staffing and administrative fees and provided sufficient funds for subsidised therapy. If just one person in 150 that asks StopSO for help receives effective therapy, and as a result does not commit a crime, then StopSO is cost effective. If just 10 per cent of (potential) perpetrators that have asked StopSO for help are no longer imprisoned, StopSO therapists save the taxpayer almost £8 million.

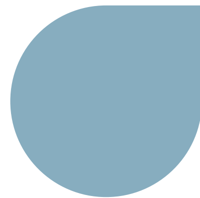
In many instances, therapy can make all the difference. By treating the early trauma, and working on strategies to help clients stay law abiding, we can change their lives. ●

▶ *StopSO has no government funding and needs £250,000 a year (less than the cost of jailing four people for a year). To donate, please visit stopso.org.uk*

Notes: *On 18 March 2018 (National Child Sexual Exploitation Awareness Day), StopSO announced that whilst its main work will remain with perpetrators of sexual abuse, it will expand its services to include offering therapy to those people who have been sexually abused, hence the new name, The Specialist Treatment Organisation for the Perpetrators and Survivors of Sexual Offences. StopSO would like to give special thanks to Sarah Bird for editing the articles in this section.*

COULD YOU WORK WITH SEX OFFENDERS?

Dr Terri Van Leeson explains what it's really like to work with sex offenders and why more therapists are needed in this vital and rewarding area



DR TERRI VAN LEESON **is a forensic psychologist** who has worked extensively with life sentenced and sex offender clients. She previously worked in the Dangerous and Severe Personality Disorder Service for the NHS in the category A Prison Estate

Throughout my 15 years working with convicted sex offenders as a forensic psychologist, one issue continued to strike me. Many of the men had tried to get help for their problems before they offended, but to no avail. This left many feeling isolated and confused – and worse, they went on to offend.

Clearly, we were missing vital opportunities to avert potential catastrophic damage to children. I wondered, 'How can I use my skills differently, to head off crime before it even occurs?' That's why I now also work with StopSO, the national charitable organisation which offers an innovative way of preventing child sexual abuse.

A CHALLENGING MOVE

I sometimes found those first years of my work with sexual offenders against children difficult. It was emotionally challenging, particularly when I also had a young child of my own.

However, with good clinical supervision and space to process when I was triggered, I gradually became more adept at bolstering my resilience, becoming a more effective practitioner. I learnt to be congruent, accepting and empathic towards clients. They need that more than anything else – so many experience high levels of shame, one of the most debilitating and dehumanising emotions – don't underestimate how much might be in the room. You must be able to deal with both the client's shame and your own disgust, which may be triggered regarding the offence, or the client's sexual thoughts.

It is essential to put pre-conceived ideas aside, and realise that some of the client's upbringing and sexualised experiences, including their trauma, may be very significant events. Many of my clients have been systematically sexually and violently abused, so understandably, they have grown up with a distorted experience and beliefs about the function of sex, children and boundaries. It can be difficult to explore their idea of children as sexually knowing and robust, a world view so different from our social, moral and ethical norms. However, unless we provide that supportive therapeutic space for them to examine their assumptions safely, those ideas will remain fixed.

THE CLIENT CONTRACT

The issue of contracting has presented challenges. Apart from the usual topics of payment, sessions and cancellation arrangements, many of my clients refuse to sign anything. They're worried that the minute they open up, I'm going to tell the police – although in fact there is no need to do so unless a client is actively offending. At times, I have worked with clients without any written contract, to ensure they keep coming. It goes against teaching, but in some cases, working at this highly responsive level has been essential to facilitate client engagement.

Actively managing dynamic risk with clients who have a clear sexual attraction to children is a process you need to deal with openly, and one that can change quickly. I am honest with my clients, telling them what I will report to the authorities. But I am also clear that I won't overreact. StopSO has a supervision network to call on if this work falls beyond the scope of your usual supervisor.

Whilst I safety-plan with a client if they feel at risk of offending, there are other clients who label themselves as 'virtuous paedophiles' or 'minor-attracted persons' who have never offended and have no desire to do so. This is most common with very young men, but the risk of harm to others, particularly children, differs. Each intervention must be bespoke, targeted to meet changing needs and risks, in addition to longer-term goals.

UNHEALTHY THOUGHTS

When a client is asking for help to manage intrusive, unhealthy sexual thoughts, I start with immediate coping skills, offering psycho-education about their urges, distraction techniques and mindfulness. I also take them through the process in a session so they have a visceral experience of it before they leave the room.

Some clients attend just one session. Having a psycho-educational input about sexual development and why some people become sexually aroused to children is enough to help them. Others may need fortnightly sessions over a year or more. Additionally, this type of work can involve other family members. It's not unusual for a man to turn up for his first session with his wife. The men (and occasionally women) I continue to work with are human and they are struggling to get their needs met in a healthy, adaptive way. Those who come through StopSO are openly asking for help.

THE THERAPEUTIC TOOLBOX

As a therapist, you will already have most of the skills to work with these clients. You may use psychoeducation, your empathy, congruence, ability to reflect, mindfulness and distress tolerance techniques. There are also specific techniques for working with men who are having unhealthy, sexually intrusive thoughts. Additionally, but only if trained, you might work with people who have sexual dysfunctions.

Further helpful knowledge includes awareness of the criminogenic aspects – deviant sexual interests, sexual preoccupation, attitudes tolerant of sexual crime, a lack of intimate relationships with adults, antisocial lifestyle, impulsivity and low self-control, employment instability, negative peer associations, substance abuse and poor problem-solving abilities. Research shows that addressing these can be the best way to prevent reoffending.

StopSO is deeply committed to offering face-to-face therapy for anyone who finds themselves sexually attracted to children but doesn't know where to turn for help. These clients are incredibly rewarding to work with – I'm making a real difference by offering focused therapy to young men who know they are sexually attracted to children and don't want to offend. Most importantly, I am making a difference by protecting current and future generations of children from being sexually abused. ●

▶ *Find out more: pathwayps.co.uk/associates/dr-terri-van-leeson.html*

Case study

Jimmy's story

Dr Van Leeson's client was a scared ex-convict, in danger of re-offending. Here's how therapy changed his perspective

'Jimmy'* had briefly been in prison for a sexual offence against a child and worried he might re-offend. He worked with me for 15 sessions and was eventually able to understand why he became sexually aroused to children.

'Jimmy grew up in a violent family and we worked through the impact of that. We explored the way Jimmy thought about children, and I challenged his assumptions. He didn't realise that, even if a child was, as he perceived it, 'flirting' with an adult, that did not mean they wanted sex. Over time, he recognised the adult's responsibility to hold the boundary.

'Jimmy's therapy included modified covert sensitisation, a technique that redirected his thinking. We considered the devastating consequences if he acted on his triggers and discussed the pride he would feel at self-control. His repertoire of healthy sexual activity developed and his life improved, because he no longer felt self-loathing or alienated from the rest of society. His dynamic risk of harming a child in future had dramatically reduced.'

A rewarding challenge?

One forensic therapist working with sex offenders explains what works, and outlines new approaches therapists can take

Dr Kerensa Hocken, Chartered Forensic Psychologist

'Breaking down denial is now thought to break down functionality for wellbeing, a protective factor for non-offending. Instead, we now help offenders create distance from their offender identity, to build a pro-social sense of self, reducing shame, but taking responsibility for behaviour. There is no collusion of "poor you".

'Therapists need core skills: the ability to be warm and supportive, ask difficult questions, and share direct thoughts non-judgmentally. New therapists can be too challenging, and not therapeutic enough — it's important to have a balanced view, and not pathologise the behaviour. This work needs experienced, confident therapists. Get good supervision and CPD and work on your self-awareness. Network with people who work with this group and read the desistance literature.

'I am careful with my use of language. My clients are "people with sexual convictions".

'Some do reoffend: good supervision from the probation service, post-prison, is essential.

'I've never had to report behaviour to police, but I have worried about someone. Still, I don't think we need mandatory reporting in ethical private practice. Prevention is cost effective and achievable, and changing perceptions must be part of government strategy.'

Interview by Dana Braithwaite, Co-founder of StopSO, COSRT Accredited Sexual and Relationship Psychotherapist, Specialist Supervisor

Your opinion

Have you worked with sex offenders, or would you consider it? Let us know: **editor@psycho-therapy.org.uk**

Special section / StopSO

THE TROUBLE WITH SHAME

Dr Andrew Smith, who trains therapists for StopSO, on the connection between shame and sexual offending

DR ANDREW SMITH has been working in the area of sex offending for 13 years. He is the author of *Counselling Male Sexual Offenders: A Strengths-focused Approach* (Routledge, 2017)

Shame and its related forms – embarrassment, disgust and stigma – can be viewed, positively, as regulating anti-social behaviour. Shame has been utilised restoratively, through 're-integrative shaming', whereby an offender meets his victim to learn about the harmful consequences of his actions. However, for this or any other form of rehabilitation to be effective, it has been argued that an offender must develop a 'redemptive script' of his life through therapy, where his essential 'good self' is developed or re-established.*

This distinct dualism between shame and guilt can be viewed as a social construction. However, the therapeutic journey from shame to guilt can provide a conceptualised framework for working with sex offenders who experience high levels of shame, and research evidence indicates rehabilitative benefits of helping clients escape a shame-saturated identity.

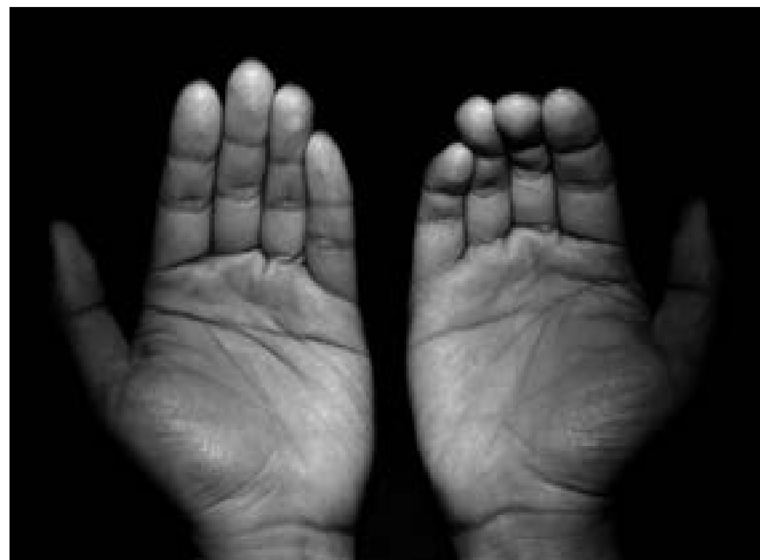
LEFT AND RIGHT BRAIN THINKING

Many sex offenders have deep-seated attachment problems and have experienced trauma and abuse. DeYoung (2015) relates chronic shame to such dysfunction and lack of adequate attunement by care-givers. Taking a psychoanalytical and neuro-scientific perspective, Shore (2012) posits that 'good enough' parenting inculcates a positive 'ego ideal', hardwiring the message of, 'I should give myself a bad time if I fall short, but not that bad a time' (a functional left-brain guilt response). However, pre-rational shame impulses are predominantly located in the right brain hemisphere. If shame is linked to early developmental problems, the offender will be unable to engage with a rational consideration of guilt, until the early attachment and trauma wounds are tended to by a therapist, providing the emotional attunement and regulation missed in childhood. Once this is achieved, left-brain, strengths-based cognitive-behavioural rehabilitative goals can be worked towards, although the treatment pathway for each individual will be different. These include meeting social, emotional and sexual needs in pro-social rather than anti-social ways, enhancing emotional regulation, restructuring cognitive distortions (if motivated), raising awareness of consequences of offending (if motivated), encouraging a safe, but satisfying sexual fantasy life and safety planning.

Many sex offenders not only have to cope with subconscious, right-brain shame, but also left-brain conscious awareness of the pariah status of a sexual conviction, compounding deep-lying shame schemas. The shame of sexual offending becomes their 'master status' or 'extended identity' – the offence becomes the person.

Instinctive disgust about sexual abuse of children is magnified by the mass media search for attention-grabbing headlines, trading in good and evil archetypes within a risk-averse society that demands protection from its folk devils, independent of the objective risk of sexual re-offending.

Female sex offenders can suffer from an additional source of shame, with their sexual offending activating collective unconscious archetypes of 'loving mother' and 'terrible mother'. The loving mother is idealised: the 'terrible' one split off, and projected onto the demonised other, rendering female sex offenders particular repositories of shame.



SHARING THE SHAME

When working with victims of sexual abuse, the potential for 'vicarious traumatisation' is significant. Pearlman and Saakvitne (1995) posit that although there is some overlap with 'burnout', vicarious traumatisation is not simply emotional exhaustion or a consequence of the gap between clinical aspirations and the reality of everyday clinical work, as in 'compassion fatigue'. Vicarious traumatisation is not connected to a specific client or relationship. It occurs cumulatively across time and place and, in addition to classic trauma, can result in disruption to the therapist's sense of identity, world view and spirituality, triggering shame about indifferent or hostile feelings towards clients.

'Vicarious traumatisation can leave the therapist serious, cynical, sad. He may develop an increased sensitivity to violence, or be prone to bouts of grief and despair... It can affect his ability to live fully, to love, to work, to play, to create'
(Pearlman and Saakvitne, 1995).

Close engagement with the lives of victims, and empathising with abuse experiences, can lead to vicarious traumatisation. However, fear of getting too close to offenders' accounts of sexual abuse can result in the practitioner becoming conflicted about the overlap between empathy and collusion.

If the therapist has not worked through personal experiences of abuse and disempowerment, this may compound the sense of emotional conflict, with a potential for punitive or punishing practice to ensue, resulting in a shame reaction. Working with offenders who deny and minimise their sexual offending can mean therapists feel deskilled, leading to cynicism and moral outrage.

Such hostile feelings towards clients can undermine the therapist's ego ideal, again producing shame.

For practitioners working with sex offenders, engagement is more problematic as the perpetrator can often also be a victim of sexual abuse and other traumas.

The majority of victims of sexual abuse do not go on to sexually abuse others although the evidence from my clinical practice is that many sex offenders have suffered sexual abuse and been exposed to a set of interlinked, highly stressful, abusive life experiences, including experiencing and witnessing violence. There is also the here-and-now distress of being unable to have contact with their children, due to (usually necessary) child protection issues, and rejection by family and friends.

Providing holistic therapy to sex offenders must include addressing right-brain victim issues related to attachment, trauma and shame problems, enabling the offender to eventually engage in left-brain cognitive-behavioural work, more typical of orthodox sex offender rehabilitation programmes. This requires the forming of a therapeutic alliance based on the three 'core conditions' of unconditional regard, congruence and empathy.

COMMON FEARS

Some who have committed a sexual offence do go on to build a constructive, non-offending lifestyle, although the road is hard, and some offenders remain outside society. Ongoing therapeutic engagement with the colossal negative impact on a person's life of sexual offending can be attritional, an additional source of vicarious traumatisation.

Another source of therapist shame can be intrusive sexual thoughts about abusive material disclosed by the client. Erotic transference between therapist and client is well documented, with sexual transference and counter-transference issues fairly routinely discussed in supervision. However, experiencing voyeuristic interest in deviant sexual acts or such acts triggering arousal in the therapist can be particularly shame-inducing.

If the client sexually re-offends whilst on the practitioner's watch, catastrophic thoughts can arise in the therapist's mind about professional censure, or being named and shamed. When I train therapists for StopSO (Specialist Treatment Organisation for the Perpetrators and Survivors of Sexual Offences), the most anxiety-inducing topic is, 'What would happen if a client offended?' As with any form of harm, there can never be any guarantees, even after all good practice guidelines have been followed. However, the prospect of public shame if a client commits a sexual offence against a child is perhaps greater with this client group than with any other.

For the clients I work with, the most damning conferred identity is that of 'paedo', and many professionals who work with sex offenders fear shame by association. A process of feared moral contamination and pollution can be at work, through contact with this demonised client group.

GOOD PRACTICE

In order to work effectively with sex offenders, therapists need to have worked through their own personal shame issues, often through their own therapy. They also need to be able to acknowledge, understand and share vicarious traumatisation symptomology with a supervisor who understands this phenomenon and the particular potential shame issues attendant on working with sex offenders

For many sex offenders suffering from early attachment and trauma problems, it will be necessary to address right-brain shame issues through the healing qualities of the therapeutic relationship over time, before addressing left-brain cognitive restructuring. Throughout the process, good supervision can enable therapists to keep perspective, leading to a healthy work-life balance, and avoiding the dual therapeutic evils of over or under-emotional involvement with this group of clients. ●

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DEEPER INTO DARKNESS: DOES VIEWING IMAGES LEAD TO CONTACT OFFENDING?

Michael Sheath examines the path from viewing illegal images to acting out, and finds both complexity and hope

MICHAEL SHEATH from the Lucy Faithfull Foundation has been working with men who use the internet to acquire CSAM since 1995. He has undertaken published research on online groomers, and in 2013/2014 he undertook a Professional Certificate in Counselling relating to Sex Addiction

It's usually moral considerations shaping any discussion of online consumers of child sexual abuse material (CSAM). Contempt is justifiably attached – they are complicit in the sexual exploitation of children – yet this understandable approach often blurs necessary considerations of direct risk. Many observers rely on 'common sense' beliefs. They assume the possibility that a man viewing sexual images of children might develop sexual fantasies which he will act out, and that men found in possession of CSAM may be already engaged in the sexual abuse of children.

Yet consensus suggests that most men newly discovered as CSAM viewers have no criminal history. Seto's (1) consideration of a wide range of studies revealed that only around 12 per cent of men convicted of viewing CSAM had prior convictions for contact offending. The most recent study, by Krone (2), suggests 86 per cent of a cohort of Australian men had no prior convictions at the time of their arrest for CSAM possession. Significantly higher rates of previous sexual misconduct have been discovered in studies using self-report, most significantly in Burke and Hernandez's 'Butner' study (3), which suggested that 84 per cent of their sample of 155 men admitted to molesting large numbers of children, although only 13 per cent had prior convictions. However, the Butner study has been criticised for methodology, and is generally seen as a 'statistical outlier' (4).

SOCIETY'S SECRET

The obvious difficulty in retrospective studies is that the same methodologies applied to men with no convictions at all may reveal a surprising level of previous sexual misconduct. The fact that around 80 per cent of all child molestation goes unreported suggests a significant number of undiscovered child molesters must exist. It may be the case that a sample of men convicted of possessing CSAM will contain a higher than average proportion of unrevealed child molesters: as a matter of social policy, viewers of CSAM should be rigorously assessed.

The second issue in terms of 'direction of travel' relates to recidivism. Recidivism is not, of course, a measure of reoffending; most child molestation is never reported, very little results in a conviction. Taking that into account, the revealed rate of recidivism of CSAM viewers seems very low, with Seto indicating a recidivism rate of just two per cent for contact offences and 3.4 per cent for further CSAM offences, albeit over a relatively short follow-up period of between two and six years. Krone's recent study of Australian men suggests 93.4 per cent of a cohort of 152 did not generate any new conviction for a sexual offence after a four-year follow-up. Compared to 'contact' offenders, who average a recidivism rate of 12 per cent to 13 per cent, 'viewers' appear to desist at a substantially greater rate (6).

The substantial difficulty for police and safeguarding authorities remains: how to differentiate between those who pose a direct risk of contact offending and those who, however closely connected to the sexual exploitation of children, do not.

One approach may be to consider explanations of CSAM viewing which do not rely solely on the conduct of child molesters, and which are not located only in sexual attraction and ambition towards children.

The Lucy Faithfull Foundation has developed a model for considering the underlying causes of CSAM viewers' conduct, using perspectives from the 'traditional' sex offender theory school, alongside the 'sex addiction' school. This model suggests a repetitive and potentially escalating series of behaviours based on viewing and downloading of both CSAM and 'mainstream' pornography. Our experience in running groups for viewers of CSAM suggests that few, if any, are solely viewers of CSAM, and that all of them 'graduated' to CSAM via conventional pornographic sites *(see diagram, below)*.

Origins suggests that the roots of CSAM viewing are often located in childhood. Early exposure to pornography is common. What men 'learn' from this is important: many develop a relationship with pornography, and use it as a comfort when they feel unhappy. Others develop expectations, based on misogynistic or brutal stereotypes. Dysfunctional schema, about the acceptability of rape, the entitlement of men to 'release' and the rejection of the idea of harm caused by sexual offending, may feature. Pornography available online might amplify deviant schema, or create them.

Triggers may not exist for all offenders, but they are common, and typically consist of events leading to dysphoria, whether sudden, such as debt, or chronic, e.g. a problematic marriage. Through habit, individuals often seek solace or distraction through pornography. Online sexual behaviours are amplified and made more reckless by the promise of anonymity, (which reduces shame), the availability of diverse forms of pornography, and affordability.

The drivers in the model relate to psychological forces which affect viewers of all forms of pornography. The Coolidge Effect (7) suggests that pornography's effect has diminishing returns in terms of maintaining the viewer's interest, and the constant search for novelty pulls viewers towards increasingly extreme subject matter. The Bikini Effect (8) suggests that viewers experiencing sexual arousal are more likely to behave impulsively, while the Skinner Box Effect (9) suggests that viewers become bound up in collecting. Flow theory (10) suggests the viewing

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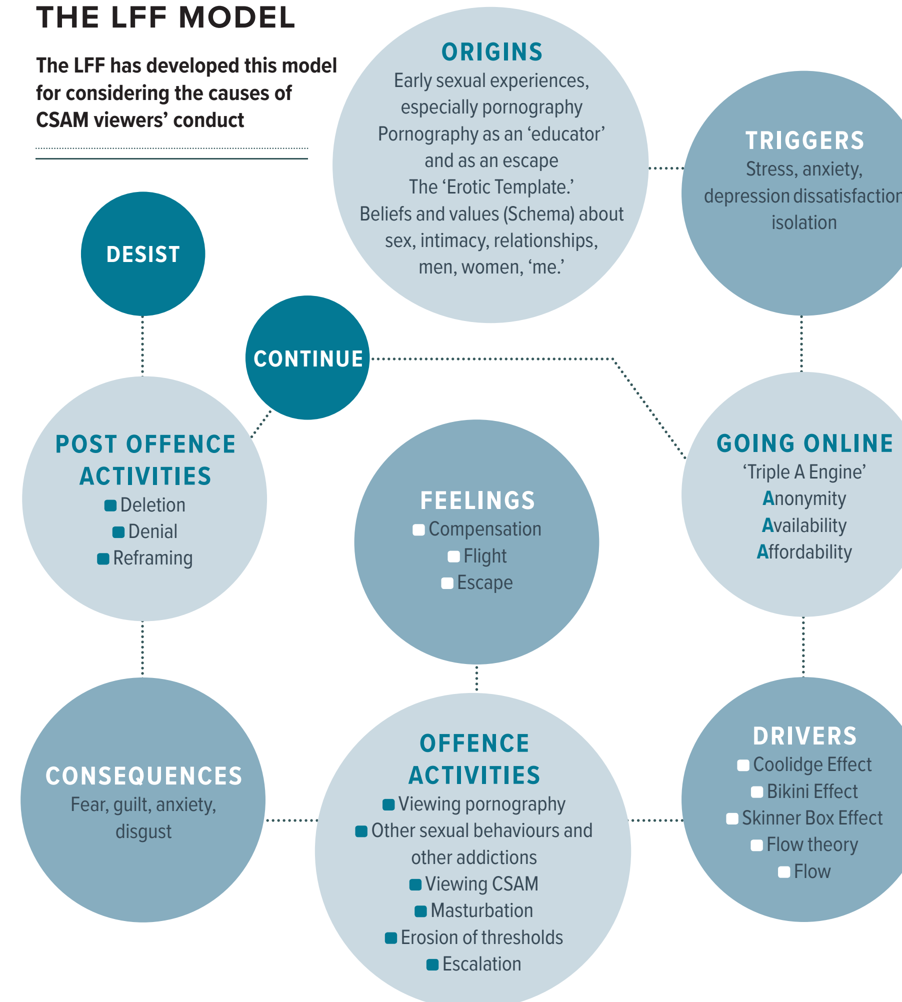
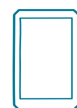
Causes of CSAM viewing





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and collecting of pornography and CSAM allows for immersion and generates a sense of focus and attainment, albeit through illegitimate means. Thus, the process becomes an end in itself, as opposed to shaping the viewer's sexuality.

INCREASED ISOLATION

Offence activities include searching for, collection and viewing of CSAM, as well as other material such as fantasy stories, and online conversations. Aside from unambiguously abusive behaviours, offenders may also engage in online sexual chat with adults, webcam sex, or gambling as well as 'offline' activities – phone sex lines, drug consumption or alcoholism, frequently replacing one addiction or distraction with another. Masturbation provides reward for deviant thoughts, further disinhibition, and a drive to repeat behaviours and offences. Over time, thresholds as to the acceptability of material erode, with increasingly abusive or sadistic material being viewed: offenders may be surprised how far they are prepared to fall morally, since most will have, offline, conventional views about children and sex not matched by their online behaviour. Many will insist that what they are viewing is 'only pictures', or represents past events over which they have no control.

Feelings experienced during viewing vary. Alongside sexual arousal there are many others, including generic excitement, escape, numbness, astonishment, and nausea. The common thread seems to be that feelings arising from viewing both pornography and CSAM tend to obliterate the feeling that existed before viewing: the 'trigger' feeling is subsumed to the feeling arising from the offence.

Consequences of offending, prior to arrest, primarily exist in the offender's mind. Many describe a range of negative emotions as soon as they disconnect from the internet, others as soon as they ejaculate. Fear of discovery or arrest may intrude; guilt, self-hatred and self-disgust are often experienced. They may, in relationship terms, move away from existing friendships and intimacies because of an inner feeling of unease and vulnerability, since having an honest relationship with someone might require them to disclose what they are doing. This retreat increases isolation, and causes further dependency on the internet.

Post-offence activities consist of practical efforts to remove traces of the online activity, but other mental processes occur as attempts to return to normality. These might include promises made to the self to desist from further viewing, or justification, that it is 'only looking', that the children involved are enjoying themselves, or that their suffering may not matter because they are unknown. If the underlying stresses at the core of the offender's behaviour are not resolved, he is very likely to continue to use CSAM. Most offenders will try and fail to desist.

The CSAM cycle, as a model of explanation, points to the urgent need for robust, research-based risk assessment of CSAM viewers, so those who pose a direct risk to children can be differentiated from those who have exploited children indirectly. No assumptions should be made about either prospective risk or retrospective behaviour. Neither group, of course, is blameless – and all need to be held to account. ●

A CHANGE OF DIRECTION

If you're interested in working with sex offenders, **Juliet Grayson** offers advice on where to train

Working with people who have committed (or might commit) a sexual offence is a specialised field. At the very least, therapists need to:

- Think about how to keep themselves safe
- Know the basics of the laws around sexual offending and the legal requirements about reporting illegal behaviour
- Develop a proportionate response to risk
- Think about the ethical issues involved in this work including reporting (and not reporting)
- Consider their own reaction to working with sex offenders, including arousal, disgust, and vicarious trauma
- Understand the dynamics of working with these clients, some of whom are experts at manipulation and grooming
- Be aware of the criminogenic and other factors that research suggests will reduce sexual reoffending
- Know what is within their competence and when to refer on
- Be aware that clients might not be direct, due to feelings of fear and/or shame. For example, a client who starts therapy for depression, and after months admits to looking at child abuse images as a way of 'calming himself down'. I recommend that all therapists have some Continuous Professional Development (CPD) for situations such as this.

WHAT STOPSO CAN OFFER

StopSO (The Specialist Treatment Organisation for the Perpetrators and Survivors of Sexual Offences) offers therapists a three-day Foundation Training course, (if preferred, therapists can just attend one or two of these days). StopSO also offers a 10-day Certificate in Therapeutic Practice with Sex Offenders, and various ad-hoc training days, good practice days, and peer supervision days.

STOPSO FOUNDATION TRAINING (3 DAYS)

This consists of three one-day workshops accredited for CPD by the College of Sex and Relationship Therapists (COSRT):

- **Crossing the Line Day:** Provides information about the legal and ethical position when treating those at risk of committing a sexual offence, foundational knowledge on why individuals commit sexual offences, and explores the emotional demands of working with this client group, including distinguishing between duties of care.
- **Assessing Risk Day:** Provides a framework for assessing individuals accused or convicted of a sexual offence, in order to help therapists make informed decisions about whether they are competent to work with a given client, whether or not to maintain confidentiality, and helping therapists to make case formulations based on relevant risk and criminogenic factors.
- **Treatment Interventions Day:** Provides a historical perspective on treatment intervention for this client group, and explores how a range of therapeutic models and approaches can be applied to working with individuals who pose a sexual risk.

STOPSO DEEPER TRAINING (10 DAYS)

StopSO offers the Certificate in Therapeutic Practice with Sex Offenders, accredited for CPD by COSRT. Open to those who have completed the three-day Foundation training. Covers:

- Emotional issues for practitioners
- Attachment and trauma issues
- Power and control issues and paraphilias
- Sexual assault and rape
- Working with female offenders
- Paedophiles: offending and non-offending
- Working with adolescents
- Internet offending and sexual addiction
- Working with family members
- Couple work

stopso.org.uk/profcert

OTHER TRAINING

- The Lucy Faithfull Foundation runs training days for professionals. *lucyfaithfull.org.uk*
- The National Organisation for the Treatment of Abusers offers workshops, (though not specifically for psychotherapists). *nota.co.uk*
- The NHS Portman Clinic offers two-year training leading to a qualification with the British Psychoanalytic Council and shorter courses looking at forensic issues. *tavistockandportman.nhs.uk*
- The Institute for Sex Addiction Training provides an Accredited Diploma in Sex Addiction Counselling. *instituteforsexaddictiontraining.co.uk*
- The Marylebone centre offers an Accredited Diploma in Sex Addiction *marylebonecentre.co.uk/professional* ●

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A LEGAL MINEFIELD: WHEN SEX OFFENDING COMES TO COURT

Peter Jenkins looks at the recent rise in reporting and prosecutions of sexual offences and what that means for psychotherapists

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We live in a 'post-Savile era', where there is much greater awareness of sexual offending than ever before. Between 2011 and 2016 there was a 60 per cent increase in child sexual abuse cases reported to police. Police sexual abuse caseloads doubled during this period. Recent cases accounted for 80 per cent.

Social media has opened up new forms of sexual abuse, too. One survey of 50 schools identified 1,218 pupils who had either sent or received a 'sext' since 2012. Overall, this suggests that up to 44,000 secondary school pupils were affected by sexting during the period 2012-2016 (Mostrous and Rigby, 2016). Sexting, in turn, can lead to revenge porn, or 'sextortion' (blackmail) by organised crime groups.

Growing awareness of the scale is reflected in the current National Inquiry into child abuse,and one outcome might be mandatory reporting, although abuse reporting rates in the UK are already high and this could represent a significant legal challenge to the current boundaries of therapeutic confidentiality. However, government ministers have recently confirmed that a mandatory system of abuse reporting will not now be introduced for England, given that most professionals in the field do not support this measure.

A DUTY TO REPORT?

Therapists working for the NHS or other agencies need to report child sexual abuse. Psychologists regulated by the Health and Care Professions Council also have a duty to report. However, therapists in private practice have no legal duty to report child sexual abuse, though they may do so 'in the public interest'.

There have also been major changes in how the police and the Criminal Prosecution Service (CPS) respond to, investigate and prosecute reports of rape and sexual assault. The CPS has brought an added emphasis in prosecuting cases of alleged rape and sexual assault and the number of CPS specialist rape lawyers has doubled to 80 in the last year. However, the CPS and police force have been affected by public sector cuts. The number of rape claims (almost exclusively by women) recorded in England and Wales has more than doubled, from 10,000 in 2011-2012, to 24,000 in 2015-2016. Recorded rapes of children also doubled, rising from 5,878 to 11,947, during the same period. But while the number of convictions has increased, the ratio of convictions to recorded allegations has halved. More widely, the CPS reports an increase in successful prosecutions for child sex abuse offences: a conviction rate of 75 per cent.

CPS policies have been revised to enable victims of historic sexual offences to challenge a past decision not to prosecute. Prosecution efforts are now to be evidence-led, not focused on victim credibility.

Many therapists will be familiar with clients bringing a criminal prosecution for rape or sexual assault. Stress can be increased by delays, the scrutiny of witness testimony, and fear of being disbelieved.

One survey found that rape stereotypes damaging to the complainant's case were found in 26 out of 30 cases, including one under 18. This prompted a Private Member's Bill by Liz Saville-Roberts, a Plaid Cymru MP, designed to prevent the use of evidence concerning the alleged victim's past sexual history. Cross-examination of witnesses can now take place prior to the trial on video, limiting potential distress.

The CPS's Practice Guidance on pre-trial therapy for children and vulnerable adult witnesses also specifies that certain types of therapy be avoided, to avoid 'contaminating' their evidence. Therapy can continue prior to a criminal trial, but the CPS must be informed (with client consent). Records may be made available to both prosecution and defence.

Given the increasing attention on sexual abuse and exploitation in the media, disclosure of past abuse seems increasingly likely to figure in the work of many psychotherapists.

This raises the question of whether all therapy now needs to be considered as potentially moving onto the terrain of pre-trial therapy. Therapists working with non-recent disclosures of childhood sexual abuse can face the prospect of past notes becoming evidence in a criminal trial, sometimes many years after the completion of the therapeutic work, with therapists then being called as witnesses. ●